

Arizona Department of Health Services
Office for Children with Special Health Care Needs

**VOLUNTARY REQUEST TO CLOSE / REOPEN
TBI/SCI/CYSHCN
FAMILY RESOURCE COORDINATION SERVICES**

I, _____, certify I am _____
(Responsible Party) (Mother/Father/Legal Guardian, etc.)
of _____.
(Member's Name)

I WOULD LIKE THE FOLLOWING ACTION TO BE TAKEN: (Check and fill in the required information)

☐ Reactivation of TBI ___ SCI ___ CYSHCN ___ Family Resource Coordination Services

☐ Current Address/Telephone Number

(Telephone Number)

☐ Discontinue TBI ___ SCI ___ CYSHCN ___ Family Resource Coordination Services. I am requesting discharge from your services for the following reason:

☐ Services no longer needed

☐ Other: (Please state the reason)

Signature

Date

C: member file

Leadership for a Healthy Arizona